

18-018
ong
ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT

RECEIVED

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

JUN 27 2018

This Section must be completed for all projects.

HEALTH FACILITIES &
SERVICES REVIEW BOARD

Facility/Project Identification

ASTC 00005599

Facility Name:	North Suburban Pain and Spine Center		
Street Address:	9680 Golf Road (approx. - legal description provided)		
City and Zip Code:	Des Plaines, IL 60016		
County:	Cook	Health Service Area:	VII Health Planning Area: 31

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

05698

Exact Legal Name:	North Suburban Pain and Spine Center, LLC
Street Address:	9680 Golf Road
City and Zip Code:	Des Plaines, IL 60016
Name of Registered Agent:	Stuart Gimbel
Registered Agent Street Address:	120 S. Riverside Plaza, Suite 1675
Registered Agent City and Zip Code:	Chicago, IL 60606
Name of Chief Executive Officer:	Darrel Saldanha, MD
CEO Street Address:	9680 Golf Road
CEO City and Zip Code:	Des Plaines, IL 60016
CEO Telephone Number:	847/985-4700

Type of Ownership of Applicants

- | | |
|---|---|
| <input type="checkbox"/> Non-profit Corporation | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> For-profit Corporation | <input type="checkbox"/> Governmental |
| <input checked="" type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other |

- Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact [Person to receive ALL correspondence or inquiries]

Name:	Jacob M. Axel
Title:	President
Company Name:	Axel & Associates, Inc.
Address:	675 North Court, Suite 210 Palatine, IL 60067
Telephone Number:	847/776-7101
E-mail Address:	jacobmaxel@msn.com
Fax Number:	847/776-7004

Additional Contact [Person who is also authorized to discuss the application for permit]

Name:	none
Title:	
Company Name:	
Address:	
Telephone Number:	
E-mail Address:	
Fax Number:	

Post Permit Contact

[Person to receive all correspondence subsequent to permit issuance-THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960]

Name:	Darrel J. Saldanha, MD
Title:	Chief Executive Officer
Company Name:	North Suburban Pain and Spine Center, LLC
Address:	9680 Golf Road Des Plaines, IL 60016
Telephone Number:	630/985-4700
E-mail Address:	saldanha85@gmail.com
Fax Number:	

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner:	Remedia, LLC
Address of Site Owner:	P.O. Box 68726 Schaumburg, IL 60168
Street Address or Legal Description of the Site:	9680 Golf Road Des Plaines, IL 60016 (approx., see legal description)
Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.	
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: North Suburban Pain and Spine Center, LLC			
Address: 9680 Golf Road Des Plaines, IL 60016			
<input type="checkbox"/>	Non-profit Corporation	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	For-profit Corporation	<input type="checkbox"/>	Governmental
X	Limited Liability Company	<input type="checkbox"/>	Sole Proprietorship
<input type="checkbox"/>		<input type="checkbox"/>	Other
<ul style="list-style-type: none">Corporations and limited liability companies must provide an Illinois Certificate of Good Standing.Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.
--

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>).

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.40 and Part 1120.20(b)]

Part 1110 Classification:

☒ Substantive

☐ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does **NOT** have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

The applicants propose to establish an ambulatory surgery treatment center ("ASTC") consisting of two operating rooms and eight recovery stations, to be located in a building to be constructed adjacent to a medical clinics building located to the northeast of the intersection of Golf Road and I-294 in Des Plaines. The ASTC will lease space in the building, with the remainder of the building consisting primarily of physicians' offices. This Certificate of Need application is limited to the ASTC, as the building will not be owned by a licensed health care facility. Three clinical specialties are proposed to be provided: pain management, neurosurgery, and orthopedic surgery.

The proposed project is classified as "substantive", in that it proposes the establishment of a new HFSRB-designated category of service/health care facility, the proposed ASTC.

A legal description of the site is attached.

THE WEST 220.00 FEET OF THE EAST 398.00 FEET (BOTH AS MEASURED ALONG THE SOUTH LINE) OF THE EAST 1/2 OF THE SOUTHEAST 1/4 OF SECTION 9, TOWNSHIP 41 NORTH, RANGE 13 EAST OF THE THIRD PRINCIPAL MERIDIAN, LYING SOUTH OF A LINE DRAIN FROM A POINT ON THE WEST LINE OF THE EAST 1/2 OF THE SOUTHEAST 1/4 OF SAID SECTION, SAID POINT BEING 4.65 CHAINS (308.9 FEET) AS MEASURED ALONG SAID WEST LINE, NORTH OF THE SOUTH LINE OF SAID SOUTHEAST 1/4, TO A POINT ON THE EAST LINE OF SAID SOUTHEAST 1/4, SAID POINT BEING 5 CHAINS (330.00 FEET) AS MEASURED ALONG SAID EAST LINE, NORTH OF THE SOUTHEAST CORNER OF SAID SOUTHEAST 1/4 AND LYING NORTH OF THE NORTH LINE OF PARCEL T-48-127 IN DEED DATED FEBRUARY 21, 1958 RECORDED AS DOCUMENT NO. 18075628, SAID NORTH LINE BEING DRAIN FROM A POINT ON THE EAST LINE OF SAID SOUTHEAST 1/4, SAID POINT BEING 66.00 FEET (AS MEASURED ALONG SAID EAST LINE) NORTH OF THE SOUTHEAST CORNER THEREOF TO A POINT ON THE WEST LINE OF THE EAST 398.00 FEET OF SAID SOUTHEAST 1/4, SAID POINT BEING 120.00 FEET (AS MEASURED ALONG SAID WEST LINE) NORTH OF THE SOUTH LINE OF SAID SOUTHEAST 1/4, IN COOK COUNTY, ILLINOIS.

PROPERTY COMMONLY KNOWN AS: 9680 GOLF ROAD, DESPLAINES, ILLINOIS.

24 2

338.0

+ 632.6
+ 638.05
+ 632.04

PROJECT COST AND SOURCES OF FUNDS

	Reviewable	Non-Reviewable	Total
Project Cost:			
Preplanning Costs	\$ 30,000	\$ 6,000	\$ 36,000
Site Survey and Soil Investigation			
Site Preparation	\$ 33,750	\$ 11,250	\$ 45,000
Off Site Work			
New Construction Contracts			
Modernization Contracts	\$ 1,152,800	\$ 295,800	\$ 1,448,600
Contingencies	\$ 52,400	\$ 17,400	\$ 69,800
Architectural/Engineering Fees	\$ 130,000	\$ 98,000	\$ 228,000
Consulting and Other Fees	\$ 93,750	\$ 31,250	\$ 125,000
Movable and Other Equipment (not in construction contracts)	\$ 635,000	\$ 65,000	\$ 700,000
Net Interest Expense During Construction Period	\$ 43,142	\$ 14,381	\$ 57,522
Fair Market Value of Leased Space or Equipment	\$ 1,026,370	\$ 342,123	\$ 1,368,493
Other Costs to be Capitalized			
Acquisition of Building or Other Property			
TOTAL USES OF FUNDS	\$ 3,197,211	\$ 881,204	\$ 4,078,415
Sources of Funds:			
Cash and Securities	\$ 542,710	\$ 134,770	\$ 677,481
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	\$ 1,628,131	\$ 404,310	\$ 2,032,442
Leases (fair market value)	\$ 1,026,370	\$ 342,123	\$ 1,368,493
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	\$ 3,197,211	\$ 881,204	\$ 4,078,415

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No

Purchase Price: \$ _____

Fair Market Value: \$ _____

The project involves the establishment of a new facility or a new category of service

☒ Yes ☐ No

If yes, provide the dollar amount of all **non-capitalized** operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100.

Estimated start-up costs and operating deficit cost is \$ 75,000.

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.

Indicate the stage of the project's architectural drawings:

☐ None or not applicable

☐ Preliminary

☒ Schematics

☐ Final Working

Anticipated project completion date (refer to Part 1130.140): June 30, 2020

Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140):

☐ Purchase orders, leases or contracts pertaining to the project have been executed.

☒ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies

☐ Financial Commitment will occur after permit issuance.

APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable: **Not Applicable**

☐ Cancer Registry

☐ APORS

☐ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted

☐ All reports regarding outstanding permits

Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.

Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the department's or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
Medical Surgical							
Intensive Care							
Diagnostic Radiology							
MRI							
Total Clinical							
NON REVIEWABLE							
Administrative							
Parking							
Gift Shop							
Total Non-clinical							
TOTAL							

APPEND DOCUMENTATION AS **ATTACHMENT 9**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Facility Bed Capacity and Utilization

Not Applicable

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. Include **observation days in the patient day totals for each bed service**. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME:		CITY:			
REPORTING PERIOD DATES:		From:		to:	
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical					
Obstetrics					
Pediatrics					
Intensive Care					
Comprehensive Physical Rehabilitation					
Acute/Chronic Mental Illness					
Neonatal Intensive Care					
General Long Term Care					
Specialized Long Term Care					
Long Term Acute Care					
Other ((identify)					
TOTALS:					

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of **North Suburban Pain and Spine Center, LLC** in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.




SIGNATURE

Darrel Saldanha, MD
PRINTED NAME

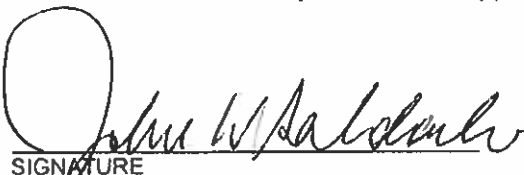
Member
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 13th day of JUNE, 2018


Signature of Notary
Seal


*Insert the EXACT legal name of the applicant

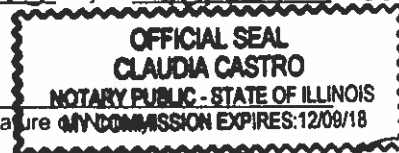


SIGNATURE

John Saldanha
PRINTED NAME

Member
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 13th day of JUNE, 2018


Signature of Notary
Seal


SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

Background

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant during the three years prior to the filing of the application.
3. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
4. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant is able to submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.230 – Purpose of the Project, and Alternatives

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** of the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost;
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes;
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.234 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. This must be a narrative and it shall include the basis used for determining the space and the methodology applied.
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. A narrative of the rationale that supports the projections must be provided.

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MET STANDARD?
YEAR 1					
YEAR 2					

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

not applicable, project involves no shell space

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

not applicable, project involves no shell space

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Colon and Rectal Surgery
<input type="checkbox"/> Dermatology
<input type="checkbox"/> General Dentistry
<input type="checkbox"/> General Surgery
<input type="checkbox"/> Gastroenterology
<input checked="" type="checkbox"/> Neurological Surgery
<input type="checkbox"/> Nuclear Medicine
<input type="checkbox"/> Obstetrics/Gynecology
<input type="checkbox"/> Ophthalmology
<input type="checkbox"/> Oral/Maxillofacial Surgery
<input checked="" type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Otolaryngology
<input checked="" type="checkbox"/> Pain Management
<input type="checkbox"/> Physical Medicine and Rehabilitation
<input type="checkbox"/> Plastic Surgery
<input type="checkbox"/> Podiatric Surgery
<input type="checkbox"/> Radiology
<input type="checkbox"/> Thoracic Surgery
<input type="checkbox"/> Urology
Other _____

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X
1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X

1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X
APPEND DOCUMENTATION AS <u>ATTACHMENT 25</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [Indicate the dollar amount to be provided from the following sources]:

\$667,48	<p>a) Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:</p> <ol style="list-style-type: none"> 1) the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and 2) interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion;
_____	<p>b) Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated time table of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.</p>
_____	<p>c) Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated time table of receipts;</p>
\$2,032,442	<p>d) Debt – a statement of the estimated terms and conditions (including the debt time period, variable or permanent interest rates over the debt time period, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:</p> <ol style="list-style-type: none"> 1) For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated; 2) For revenue bonds, proof of the feasibility of securing the specified amount and interest rate; 3) For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.; 4) For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment; 5) For any option to lease, a copy of the option, including all terms and conditions.
_____	<p>e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a</p>

	resolution or other action of the governmental unit attesting to this intent;
	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt;
<u>\$1,368,493</u>	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project. FMV of Leased Space
\$4,078,415	TOTAL FUNDS AVAILABLE
<p>APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.</p>	

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available;
- 2) That the selected form of debt financing will not be at the lowest net cost available, but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors;
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (list below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
Contingency									
TOTALS									

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT

SAFETY NET IMPACT STATEMENT that describes all of the following must be submitted for ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE STATE-OWNED HEALTH CARE FACILITIES [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in a given community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all of the following:

Not applicable...newly-formed entity

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 38.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)			
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)			
Inpatient			
Outpatient			
Total			

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI. CHARITY CARE INFORMATION

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

Not applicable...newly-formed entity

CHARITY CARE			
	Year	Year	Year
Net Patient Revenue			
Amount of Charity Care (charges)			
Cost of Charity Care			

APPEND DOCUMENTATION AS **ATTACHMENT 39**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Anticipated Payor Mix:

Medicare	30%
BC/BS	30%
Other PPOs	20%
Medicaid	10%
Worker's Comp	9%
Charity Care*	1%

*no expectation of payment prior to provision of service



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

NORTH SUBURBAN PAIN AND SPINE CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 07, 2018, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 15TH
day of MAY A.D. 2018 .***

Jesse White

SECRETARY OF STATE ATTACHMENT 1

Illinois Health Facilities and
Services Review Board
Springfield, IL 62761

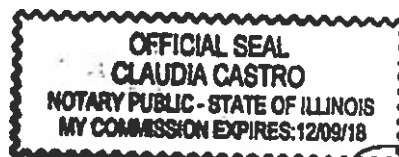
To Whom It May Concern:

I hereby certify that I am the principle owner of General Property Management, LLC, that General Property Management, LLC owns property to the northeast of the intersection of Golf Road and I-294 in Des Plaines, Illinois, and that the building located on that site (9680 Golf Road) is intended to be expanded and to include an ambulatory surgery treatment center.

Sincerely,

John W. Palolani

Notarized:



Claudia Castro

4/17/18

ATTACHMENT 2

GENERAL PROPERTY MANAGEMENT, LLC
9680 Golf Road
Des Plaines, IL 60016

June 6, 2018

North Suburban Pain and Spine Center, LLC
Attn: Darrel Saldanha, M.D.
9680 Golf Road
Des Plaines, IL 60016

Re: Ambulatory Surgery Center Project

Dear Darrel:

As you know, the undersigned is the manager of General Property Management, LLC ("GPM"), the owner of the property located at 9680 Golf Road in Des Plaines, Illinois (the "Property"). The following will confirm our discussions and agreements regarding the use of the Property by North Suburban Pain and Spine Center, LLC ("NSPS") for the operation of an ambulatory surgery center ("ASC") at the Property:

1. Within two (2) weeks of approval of NSPS' application for a Certificate of Need ("CON") by the Illinois Health Facilities and Services Review Board, GPM will enter into a lease agreement with NSPS providing for NSPS' use of not more than 7,000 rentable square feet in a building to be constructed by GPM on the Property. The term of such lease will be for a period of ten (10) years, and NSPS shall be provided two 10-year options to extend the lease. The parties anticipate that the lease will be triple net, with an initial fair market value rental rate of \$17.50 per square foot and annual increases during the term of 2.5%.

2. Within thirty (30) days of execution of the lease, GPM will commence construction of the site improvements and shell building in which the ASC is to be housed. GPM will exercise complete control over all such site improvements and construction activities; provided that GPM shall assure that the building is suitable for NSPS' proposed ASC consistent with the terms of its CON application.

3. Upon completion of the site and shell improvements, NSPS shall be responsible, at its sole cost, for the completion of any and all tenant improvements necessary for operation of the proposed ASC at the Property.

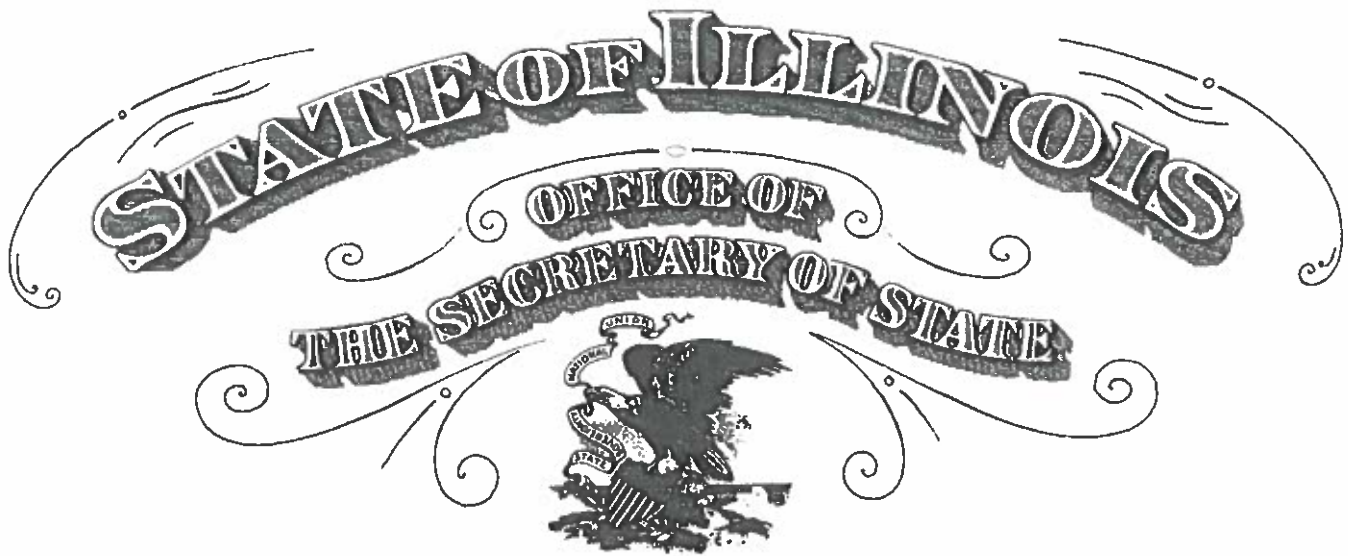
We look forward to working with NSPS on the above-referenced project. Let us know if there is anything else you need from GPM.

Very truly yours,


John W. Saldanha, individually and on
behalf of General Property Management, LLC.

cc: Stuart Gimbel, Esq.

ATTACHMENT 2



To all to whom these Presents Shall Come, Greeting:

I, Jesse White, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

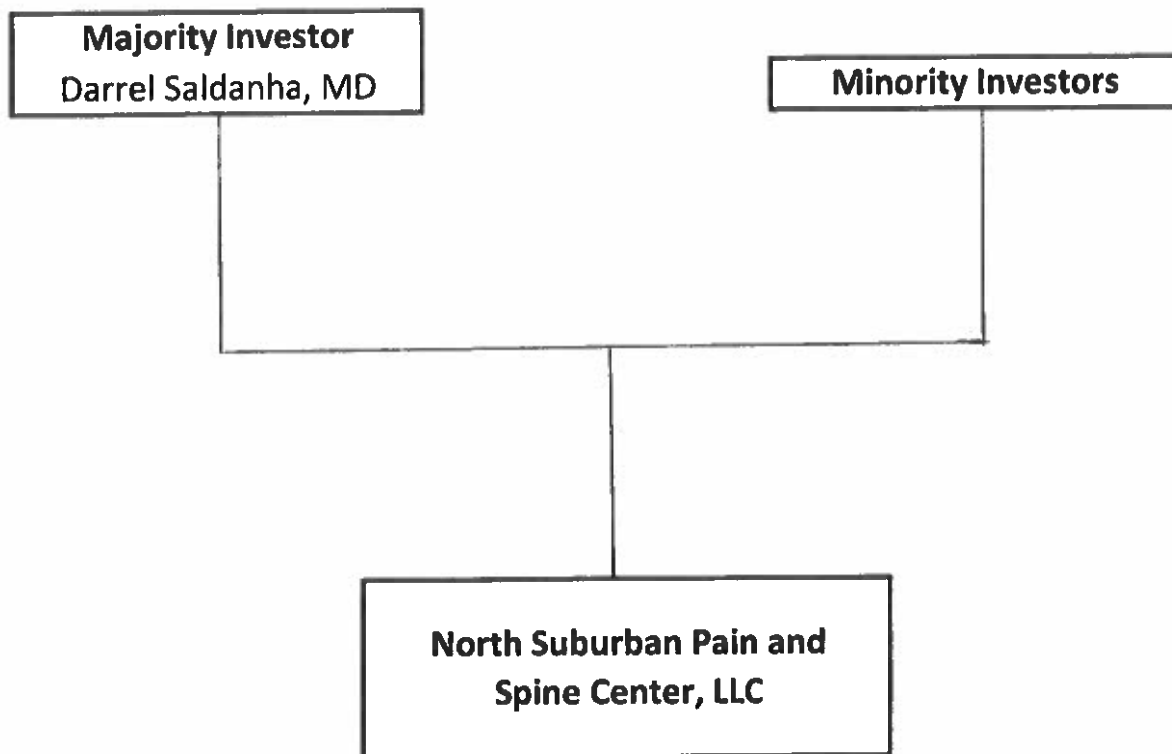
NORTH SUBURBAN PAIN AND SPINE CENTER LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON FEBRUARY 07, 2018, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



***In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 15TH
day of MAY A.D. 2018 .***

Jesse White

ORGANIZATIONAL CHART



FLOOD PLAIN REQUIREMENTS

With the signatures on the Certification page of this Certificate of Need application, the applicant confirms that the project, at the proposed site, is not in a special flood hazard area, and that the project complies with the requirements of Executive Order #2006-5. A map confirming such, and provided by FEMA, is attached.



Legend

SEE THIS REPORT FOR DETAILED LEGEND AND INDEX MAP FOR FIRM PANEL LAYOUT

Without Base Flood Elevation (BFE)
Zone A, V, AE, AR

With BFE or Depth

Regulatory Floodway *Zone AE, AO, AH, VZ, AR*

SPECIAL FLOOD HAZARD AREAS

0.2% Annual Chance Flood Hazard, Areas of 1% annual chance flood with average depth less than one foot or with drainage areas of less than one square mile *Zone X*

Future Conditions 1% Annual Chance Flood Hazard *Zone X*

Area with Reduced Flood Risk due to Levee. See Notes. *Zone X*

Area with Flood Risk due to Levee *Zone X*

OTHER AREAS OF FLOOD HAZARD

OTHER AREAS

Area of Minimal Flood Hazard *Zone X*

Effective LOMRs

Area of Undetermined Flood Hazard *Zone X*

GENERAL STRUCTURES

Channel, Culvert, or Storm Sewer

Levee, Dike, or Floodwall

OTHER FEATURES

Cross Sections with 1% Annual Chance Water Surface Elevation

Coastal Transect

Base Flood Elevation Line (BFE)

Limit of Study

Jurisdiction Boundary

Coastal Transect Baseline

Profile Baseline

Hydrographic Feature

MAP PANELS

Digital Data Available

No Digital Data Available

Unmapped

This map complies with FEMA's standards for the use of digital flood maps if it is not void as described below. The base map shown complies with FEMA's base map accuracy standards

The flood hazard information is derived directly from the authoritative NFHL web services provided by FEMA. This map was exported on 3/14/2018 at 6:45:08 PM, and does not reflect changes or amendments subsequent to this date and time. The NFHL and effective information may change or become superseded by new data over time.

This map image is void if the one or more of the following map elements do not appear: base map imagery, flood zone labels, legend, scale bar, map creation date, community identifiers, FIRM panel number, and FIRM effective date. Map images for unmapped and unmodernized areas cannot be used for regulatory purposes.





Illinois Department of Natural Resources

One Natural Resources Way Springfield, Illinois 62702-1271
www.dnr.illinois.gov

Bruce Rauner, Governor

Wayne A. Rosenthal, Director

FAX (217) 524-7525

Cook County

Des Plaines

Partial Demolition, Rehabilitation and New Addition for a Medical Clinics Building

9680 Golf Road

SHPO Log #018031218

April 11, 2018

Jacob Axel

Axel & Associates, Inc.

675 North Court, Suite 210

Palatine, IL 60067

Dear Mr. Axel:

This letter is to inform you that we have reviewed the information provided concerning the referenced project.

Our review of the records indicates that no historic, architectural or archaeological sites exist within the project area.

Please retain this letter in your files as evidence of compliance with Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et. seq.). This clearance remains in effect for two years from date of issuance. It does not pertain to any discovery during construction, nor is it a clearance for purposes of the Illinois Human Skeletal Remains Protection Act (20 ILCS 3440).

If you have any further questions, please contact me at 217/785-5031.

Sincerely,

A handwritten signature in dark ink, appearing to read "Rachel", with a long, sweeping horizontal line extending to the right.

Rachel Leibowitz, Ph.D.

Deputy State Historic
Preservation Officer

ATTACHMENT 6

PROJECT COSTS and
SOURCES OF FUNDS

PROJECT COSTS

Preplanning Costs

Market Analyses/Feasibility Assessment	\$30,000	
Misc./Other	\$6,000	

\$36,000

Site Preparation

Exterior Signage	\$ 45,000	
------------------	-----------	--

\$ 45,000

Modernization

build-out per ATTACHMENT 39C	\$1,448,600	
------------------------------	-------------	--

\$1,448,600

Contingencies

per ATTACHMENT 39C	\$69,800	
--------------------	----------	--

\$69,800

Architectural and Engineering Fees

Design	\$175,000	
Document Preparation	\$4,000	
Interface with Agencies	\$4,000	
Project Monitoring	\$5,000	
Misc./Other	\$40,000	

\$228,000

Consulting and Other Fees

CON-related	\$50,000	
Legal & Accounting	\$35,000	
Insurance, Fees and Permits	\$10,000	
Commissioning	\$15,000	
Misc./Other	\$15,000	

\$125,000

Movable Equipment

Surgical Suite

to include OR tables, microscope, anesthesia equipment, monitors, and other equipment <\$5,000	\$480,000	
--	-----------	--

Recovery Room

to include beds, recliners, monitors, computer, and other equipment <\$5,000	\$95,000	
---	----------	--

Surgical Support

to includesterilizers, racks and other equipment <\$1,000	\$60,000	
--	----------	--

Staff areas

to include furniture, lockers, computer and other equipment <\$1,000	\$25,000	
---	----------	--

Family areas

PROJECT COSTS and
SOURCES OF FUNDS

to include furniture, refreshment station, and other equipment <\$1,000	\$20,000	
Other/Misc.	\$20,000	\$700,000
Net Interest Expense During Const.	\$	57,522
Fair Market Value of Leased Space*	\$	1,368,493
Total Project Cost		\$4,078,415

*The FMV of the leased space, for purposes of this CON application is based on the lease payments during the initial term of the lease

SOURCES OF FUNDS

Mortgage/Bank Loan	\$2,032,442	
Cash-North Suburban Pain and Spine Center, LLC	\$677,481	
FMV of Leased Space	\$ 1,368,493	
Total Sources of Funds		\$4,078,415

*FMV determined as value of lease over initial term--
\$17.50/sf, escalating by 2.5% annually for 10 years

Cost Space Requirements

Dept./Area	Cost	Gross Square Feet		Amount of proposed Total Square Feet That is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
Reviewable							
ASTC-Surgery	\$ 2,290,618		2,620		2,545		
ASTC-Recovery	\$ 981,693		2,620		1,640		
	\$ 3,272,311		5,240		4,185		
Non-Reviewable							
Public Areas	\$ 257,953		600		415		
Admin/Business Areas	\$ 278,106		520		370		
Staff Areas	\$ 270,045		620		595		
	\$ 806,104		1,740		1,380		
	\$ 4,078,415		6,980		5,565		

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

To Whom It May Concern:

The sole applicant entity for the proposed project to establish an ambulatory surgery treatment center in Des Plaines, Illinois is North Suburban Pain and Spine Center, LLC, a newly-formed entity. I hereby certify that no adverse action has been taken against it, directly or indirectly; and authorize HFSRB and IDPH to access any documentation which it finds necessary to verify any information submitted, including, but not limited to: official records of IDPH or other State agencies and the records of nationally recognized accreditation organizations.



Darrel Saldanha, MD
Chief Executive Officer

Notarized:



4/17/18

ATTACHMENT 11

PURPOSE OF THE PROJECT

The proposed project will improve the health care and well-being of the market/service area population to be served.

Because of the office locations of the physicians to be referring patients to and performing procedures in the proposed ASTC, and because pre- and post-procedure physician visits will be done in the physicians' office, rather than the ASTC, the applicant defines and views the proposed ASTC's service area as being southern Lake County and Cook County.

Additionally, the proposed project will significantly improve accessibility to lower-cost pain management, neurosurgery, and orthopedic surgery services than are currently provided in the hospital setting through the establishment of an ASTC that will provide pain management and neurosurgery (primarily spine) services. The HFSRB defines the geographic service area ("GSA") for ASTCs located in Cook County as ten miles. IDPH *Facility Profiles* reveal that within the GSA, there are only eight ASTCs. Of those five facilities:

- none of the facilities provide neurological surgery services
- one facility provides only gynecological services
- one facility provides only ophthalmic surgery services
- only one facility provides pain management services
- one of the facilities does not provide any of the specialties proposed to be provided
- one facility is primarily a podiatric surgery facility, providing only 25 pain management procedures in 2016
- only one of the ASTCs performed in excess of 25 pain management procedures in 2016

The goal of the project is to reduce the reliance on hospitals for the services to be provided in the proposed ASTC in a safe and less costly manner.

ALTERNATIVES

Due to the purpose of the project...to establish a low-cost alternative for the performance of a limited scope of procedures, accessible to the residents of the geographic service area...the alternatives to the proposed project are limited.

The primary alternatives investigated were an alternative location or the renovation of existing space in the on-site building.

The selected site is at the intersection of I-294 and Golf Road, both major thoroughfares. As such, alternative locations would not provide the level of patient accessibility afforded by the proposed site. The alternative of renovating space within the existing on-site building was dismissed due to the high renovation costs resulting from the building's age, utilities and current design, which would result in significant compromises to efficient design and use as an ASTC.

The alternative of establishing an ASTC through new construction on the selected site in order to capitalize on patient accessibility and eliminate design compromises was viewed as the most reasonable alternative.

Regardless of the alternative selected, the quality of care provided would be identical. Accessibility for either alternative on the proposed site will likely be superior to that of another site. The construction-related cost associated with the new construction alternative exceeds that of the renovation alternative by approximately 20%, but those costs are viewed by the applicant

to be off-set by the resultant design, and to an extent, by efficiencies resulting from a design without limitations due to an existing structure. Last, operating costs (primarily staffing) were viewed to be similar for all options.

SIZE

The proposed project is limited to the development of an ASTC, having two Class C operating rooms, two Phase I recovery stations, six Phase II recovery stations, and associated support space. The planned spaces allocated to each function, as documented in the table below are necessary, not excessive and consistent with applicable HFSRB size standards.

DEPARTMENT/SERVICE	PROPOSED DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
Operating Rooms (2)	2,620	5,500	(2,880)	YES
Recovery-Phase I (2)	360	360	-	YES
Recovery-Phase II (6)	2,260	2,400	(140)	YES

UTILIZATION

The applicant fully anticipates that the ASTC's target utilization level of 1,501+ hours of OR utilization will be reached during the second year of operation, and that utilization will reach that annualized rate in the ASTC's second quarter of operation, following a "ramp-up" period.

Letters, consistent with HFSRB requirements have been secured from seven physicians, and are provided in ATTACHMENT 27c3. Cumulatively, these physicians anticipate referring 2,025 patients to the ASTC during the second year of operation. The individual physicians' anticipated referrals were factored by the 2016 specialty-specific surgery time for all ASTCs in HSA VII to translate referrals into anticipated OR hours. As a result, and assuming the addition of no other physicians to the ASTC's medical staff, 1,677 hours of OR time are anticipated during the second year of operation.

Dept./ Service ASTC	Historical Utilization* (Patient Days) (TREATMENTS) N/A	PROJECTED UTILIZATION* (examinations)		STATE STANDARD 1,501+	MET STANDARD? YES
		YEAR 1	YEAR 2		
		1,200	1,677		

SERVICE TO GEOGRAPHIC SERVICE AREA RESIDENTS

The geographic service area ("GSA") of the proposed project, consistent with HFSRB limitations, consists of those communities/ZIP Code areas located within 10 miles of the ASTC site, as identified in Section 1110.235. With the signing of this *Application for Permit*, the applicant certifies that the primary purpose of the proposed project is to provide ASTC services to residents of the GSA, and a listing of the ZIP Code areas included in the GSA is provided at the end of this ATTACHMENT. It should be noted, however, that because of the current office locations of some of the physicians anticipated to refer patients to the proposed ASTC, a significant portion of some physicians' caseloads reside outside of the ASTC.

As required, historical patient origin information is provided in the physician referral letters provided later in this application. It is anticipated, however, that the patient origin of some of the physicians will be significantly different following the ASTC's opening, with a higher percentage of their patients being GSA residents. The ASTC will be located adjacent to an existing medical clinics building and located in a new building that will include physicians' office space. It is anticipated by the applicant that a number of physicians that will refer patients to the ASTC will secure either full- or part-time office space in those two buildings, and a higher percentage of those physicians future patients will be GSA residents.

This *Application for Permit* addresses the establishment of an ASTC, and as such, historical patient origin information for the ASTC is not available. Consistent with the requirements of Section 1110.1540.d), however, are physician referral letters, each of which contains historical ZIP Code-specific patient origin data for the referring physician are provided.

ZIP Codes Located Within 10 Miles
of Proposed ASTC Site

60002	60130	60608
60004	30131	60609
60005	60137	60610
60006	60139	60611
60007	60141	60612
60008	60143	60613
60010	60148	60614
60011	60153	60616
60015	60154	60617
60016	60157	60618
60022	60160	60622
60025	60162	60623
60026	60163	60624
60029	60164	60625
60035	60165	60626
60037	60171	60630
60040	60172	60631
60043	60173	60632
60044	60176	60634
60045	60185	60635
60047	60188	60639
60050	60191	60640
60053	60193	60641
60060	60164	60644
60061	60195	60645
60067	60201	60646
60068	60202	60650
60069	60203	60651
60070	60301	60656
60074	60303	60657
60076	60304	60666
60077	60305	60714
60082	60402	
60088	60514	
60089	60515	
60091	60521	
60091	60525	
60093	60534	
60101	60546	
60103	60558	
60104	60601	
60106	60602	
60107	60603	
60108	60604	
60120	60605	
60126	60607	

SERVICE DEMAND

The proposed ASTC will, following a ramp-up period during the first year of operation, operate at the IHFSRB-adopted utilization level in subsequent years.

Letters from seven physicians are attached. Cumulatively, those physicians anticipate referring 2,025 patients to the proposed ASTC during its second year of operation. Surgical specialty-specific time requirements for the specialties to be provided through the proposed ASTC are identified in ATTACHMENT 27c-5, and range from .53 hours to 3.54 hours, including room turnover. As a result, it is anticipated that 1,677 hours of OR time will be used during the second year of operation.

Dept./ Service	Historical Utilization (Hours)	PROJECTED UTILIZATION (Hours)		STATE STANDARD	MET STANDARD?
		YEAR 1	YEAR 2		
ASTC	N/A	1,200	1,677	1,501+	YES

TREATMENT ROOM NEED ASSESSMENT

The proposed ASTC will provide two "Class C" operating rooms, therein requiring an excess of 1,500 hours of required time for justification, consistent with the minimum utilization standard identified in Section 1110.1540.f). As documented in ATTACHMENT 25C-3, the physicians providing referral letters anticipate performing 2,025 procedures at the ASTC during its second year of operation. Those procedures were converted to anticipated hours of OR utilization by using the specialty-specific historical hours per case identified by IDPH for ASTCs located in HSA VII during 2016. Those times are identified in the table below, and document an anticipated 1,677 hours of OR utilization. This projection is viewed by the applicant as being conservative, because it does not incorporate cases to potentially be performed at the ASTC by physicians not providing referral letters.

Specialty	Cases	Hrs./Case	Hours
Pain Management	1,700	0.53	901
Neurosurgery	150	3.54	531
Orthopedic Surgery	<u>175</u>	1.40	<u>245</u>
	2,025		1,677

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following number of patients on the hospitals or licensed ASTCs identified below.

	<u>2016</u>	<u>2017</u>
Hyde Park Surgical Center, LLC	222 patients	29 patients
Office Procedures	839 patients	948 patients

I estimate that I will refer 200 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 patients.

The information contained in this letter is true and correct, to the best of my information and belief, and had not been used in the support of another project.


Sincerely,



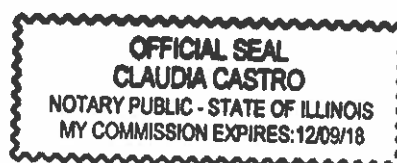
Darrel Saldanha, M.D.
Anesthesiology and Pain Medicine

Notarized:

Subscribed and Sworn to before
me this

18th day of June 2018


Notary Public



ATTACHMENT 25C5

ZIP CODE	COUNT
46320	1
60004	1
60012	1
60018	1
60130	1
60411	1
60415	1
60423	1
60428	1
60438	1
60447	1
60452	1
60457	1
60540	1
60609	2
60611	1
60617	1
60618	1
60620	1
60626	1
60629	2
60637	1
60643	1
60647	1
60649	1
60804	1
60827	1

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017, I performed outpatient surgical procedures on approximately the following number of patients on the hospitals or licensed ASTCs identified below.

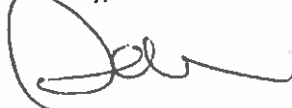
	<u>2016</u>	<u>2017</u>
Center For Minimally Invasive Surgery	77 patients	101 patients
Community First Medical Center	34 patients	20 patients
LaGrange Memorial Hospital	13 patients	11 patients
Others (See Attached)	31 patients	36 patients

I estimate that I will refer 150 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 patients.

The information contained in this letter is true and correct, to the best of my information and belief, and had not been used in the support of another project.

Sincerely,

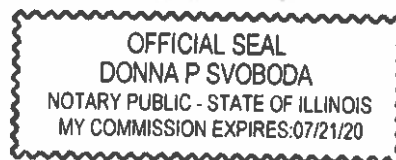


Sean Salehi, MD
Neurological and Spine Surgery

Notarized:

Subscribed and Sworn to before
me this

18 day of June 2018
Donna P. Svobeda
Notary Public



ATTACHMENT 25C5

SEAN SALEHI, MD

Adventist Bolingbrook Hospita

60440	1
60446	1
60480	1
60517	1
60538	1

Adventist Bolingbrook Hospital Total:

5

Center For Minimally Invasive :

44410	1
46311	1
46405	1
60005	1
60007	1
60008	1
60010	2
60016	2
60031	1
60042	1
60046	2
60053	1
60067	1
60074	1
60076	1
60085	1
60087	1
60090	1
60098	1
60101	2
60102	1
60107	1
60118	2
60130	1
60142	1
60164	2
60169	1
60172	1
60173	1
60185	1
60193	1
60304	1
60402	3
60403	1
60406	1
60408	1
60410	1
60411	1
60430	1
60436	2
60440	1
60441	2
60442	1
60446	1
60451	1
60453	1
60456	1
60459	1

ATTACHMENT 25C5

60469	1
60501	1
60505	3
60517	1
60525	1
60532	1
60534	1
60544	2
60554	1
60559	1
60561	1
60563	1
60586	3
60608	2
60617	1
60619	1
60623	1
60628	1
60629	1
60632	2
60636	1
60638	2
60643	1
60645	1
60647	1
60651	1
60653	1
60655	2
60683	1
60706	1
60714	1
60803	1
60901-0	1
61032	1
Center For Min Invasive Surgery Total:	101
Community First Healthcare of	
60004	1
60007	1
60060	1
60103	1
60120	1
60156	1
60160	1
60617	1
60621	1
60623	1
60625	1
60637	1
60638	1
60643	1
60647	1
60651	1
60652	1
60804	2
61326	1
Community First Healthcare of Illinois T	20
Elmhurst Memorial Hospital-Of	

60103	1
60561	1
60638	1
Elmhurst Memorial Hospital-OP Total:	3
LaGrange Memorial Hospital-O	
60103	1
60134	1
60442	1
60452	1
60453	2
60459	1
60517	2
60525	1
60544	1
LaGrange Memorial Hospital-OP Total:	11
LakeShore Surgery Center	
60181	1
LakeShore Surgery Center Total:	1
MacNeal Hospital-OP	
60007	1
60402	1
60525	1
60546	1
60638	1
60804	1
MacNeal Hospital-OP Total:	6
MetroSouth Medical Center	
46341	1
60445	1
60446	1
60447	1
60466	1
60617	1
60804	1
MetroSouth Medical Center Total:	7
Oak Brook Surgical Centre	
60513	1
Oak Brook Surgical Centre Total:	1
Preferred Surgicenter LLC	
46307	1
60098	1
60302	1
60431	1
60446	1
60544	1
60638	1
60651	1
Preferred Surgicenter LLC Total:	8
River North Same Day Surgery	
60013	1
River North Same Day Surgery C	1
South Suburban Hospital	
60466	1
60473	1
60477	1
60950	1
South Suburban Hospital Total:	4

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following number of patients on the hospitals or licensed ASTCs identified below.


	<u>2016</u>	<u>2017</u>
Advanced Ambulatory Surgical Center, LLC	57 patients	
Community First Medical Center	388 patients	
Fullerton Surgery Center	80 patients	
Preferred Surgicenter	95 patients	
Presence Saint Mary and Elizabeth Medical Center		22 patients
Hyde Park Surgical Center, LLC		94 patients
Office Procedures	437 patients	1038 patients

I estimate that I will refer 450 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 patients.

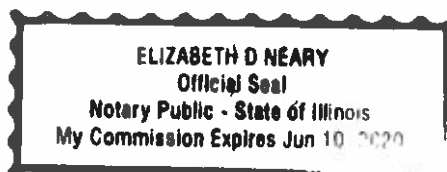
The information contained in this letter is true and correct, to the best of my information and belief, and had not been used in the support of another project.

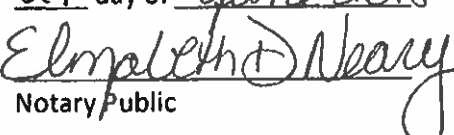
Sincerely,


Michael Rock, MD
Anesthesiology and Pain Medicine

Notarized:

Subscribed and Sworn to before
me this



21 day of June 2018

Notary Public

ATTACHMENT 25C5

Location	Count
Hyde Park ASC	94
48079	1
60016	1
60031	4
60051	2
60053	3
60056	1
60068	2
60073	1
60090	1
60123	1
60137	1
60152	1
60174	1
60193	2
60302	1
60402	2
60407	1
60416	1
60440	1
60450	2
60455	5
60458	2
60480	1
60516	1
60521	1
60523	1
60525	1
60526	1
60532	1
60534	2
60554	1
60558	1
60561	1
60564	1
60565	1
60613	2
60614	1
60618	3
60619	1
60630	4
60634	3
60638	1
60639	6

60641	4
60651	2
60655	1
60656	1
60706	4
60707	1
60714	1
60804	2
60970	1
61350	1
61364	2
61938	2
PSMEMC	22
60016	1
60025	1
60068	1
60090	1
60154	1
60420	1
60431	1
60516	1
60525	1
60618	3
60634	3
60639	1
60706	3
60707	2
60914	1
Office	1038
46405	4
47803	1
60004	3
60005	4
60007	3
60014	4
60015	7
60016	9
60018	8
60025	7
60029	1
60030	3
60034	2
60035	6
60045	3
60046	2

60047	2
60048	1
60050	4
60051	3
60053	3
60056	6
60061	6
60062	1
60067	1
60068	25
60073	2
60074	1
60077	6
60087	2
60093	4
60099	2
60101	4
60102	1
60106	3
60119	2
60120	4
60130	3
60131	2
60133	3
60137	5
60147	4
60148	1
60153	5
60155	1
60156	2
60169	5
60171	7
60174	1
60176	6
60181	3
60191	4
60193	10
60202	3
60301	1
60302	11
60305	2
60402	37
60411	5
60431	1
60432	1

60438	2
60440	2
60446	1
60451	2
60452	1
60454	2
60458	4
60459	1
60462	3
60465	5
60478	3
60491	4
60501	5
60503	4
60513	2
60515	2
60517	2
60521	1
60525	1
60527	2
60538	1
60540	2
60543	3
60544	1
60545	2
60546	7
60555	1
60561	2
60563	4
60565	4
60585	2
60601	1
60604	1
60607	3
60608	3
60609	2
60610	4
60612	8
60613	9
60614	9
60616	1
60617	1
60618	26
60619	4
60620	1

ATTACHMENT 25C5

60621	1
60622	5
60623	2
60624	3
60625	18
60629	1
60630	41
60631	16
60632	10
60633	1
60634	134
60636	2
60637	1
60638	9
60639	57
60640	11
60641	52
60643	1
60644	7
60645	7
60646	26
60647	9
60651	6
60652	1
60653	3
60655	1
60656	25
60657	10
60659	3
60660	3
60693	2
60706	48
60707	38
60712	3
60714	7
60804	27
60914	8
60928	2
60940	1
60970	1
61008	2
61065	2
61103	5
61348	1
61938	1

Grand Total:	1154
--------------	------

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017, I performed outpatient surgical procedures on approximately the following number of patients on the hospitals or licensed ASTCs identified below.

	<u>2016</u>	<u>2017</u>
Hyde Park Surgical Center, LLC	215 patients	671 patients
Office Procedures	841 patients	1032 patients

I estimate that I will refer 600 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 patients.

The information contained in this letter is true and correct, to the best of my information and belief, and had not been used in the support of another project.

Sincerely,



Andrei Rakic, MD
Anesthesiology and Pain Medicine

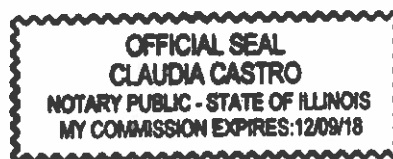
Notarized:

Subscribed and Sworn to before
me this

18th day of June 2018



Notary Public



ATTACHMENT 25C5

ZIP CODE	COUNT
40373	1
45322	1
45414	1
46307	1
46314	1
46322	3
46323	1
46324	1
46327	2
46373	1
46404	1
46405	2
46406	1
46408	4
46410	6
60007	1
60008	1
60016	6
60018	2
60031	1
60039	1
60042	1
60046	2
60053	2
60056	3
60060	1
60062	1
60067	1
60073	1
60074	2
60077	1
60085	7
60090	4
60099	7
60101	6
60103	3
60104	3
60106	3
60107	2
60120	7
60123	2
60131	1

ATTACHMENT 25C5

60133	2
60148	2
60153	3
60155	1
60160	3
60164	5
60165	2
60169	5
60170	1
60171	1
60176	9
60185	2
60194	3
60202	2
60344	1
60402	10
60406	4
60407	1
60409	10
60411	16
60414	1
60415	2
60417	4
60418	2
60419	13
60421	2
60423	1
60425	4
60426	10
60428	2
60429	4
60430	8
60432	3
60433	5
60435	1
60438	4
60440	4
60441	5
60442	2
60443	1
60445	5
60446	2
60450	2

ATTACHMENT 25C5

60451	2
60452	1
60453	4
60455	2
60456	1
60459	3
60465	5
60469	1
60471	2
60473	9
60476	1
60477	6
60478	5
60480	1
60490	1
60491	2
60503	1
60504	7
60505	1
60506	3
60511	2
60516	3
60520	2
60525	1
60538	1
60546	1
60563	1
60586	4
60601	2
60605	1
60606	1
60608	9
60609	12
60611	2
60614	1
60615	6
60616	3
60617	35
60618	6
60619	4
60620	17
60621	9
60622	4

60623	13
60624	8
60625	1
60626	1
60628	10
60629	26
60630	3
60632	7
60633	1
60634	7
60636	3
60638	6
60639	10
60640	1
60643	13
60644	7
60645	5
60646	1
60647	1
60649	9
60651	5
60652	12
60653	16
60655	1
60656	4
60659	3
60660	1
60706	4
60707	3
60803	2
60804	13
60805	7
60827	3
60901	6
60950	1
60958	2
61350	1

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following number of patients on the hospitals or licensed ASTCs identified below.

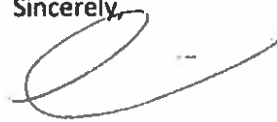
	<u>2016</u>	<u>2017</u>
Hyde Park Surgical Center, LLC	284 patients	286 patients
Office Procedures	992 patients	1024 patients

I estimate that I will refer 400 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 patients.

The information contained in this letter is true and correct, to the best of my information and belief, and had not been used in the support of another project.


Sincerely,



Thomas Pontinen, MD
Anesthesiology and Pain Medicine

Notarized:

Subscribed and Sworn to before
me this

18th day of June of 2018

Notary Public



ATTACHMENT 25C5

64

ZIP CODE	COUNT
45324	1
46254	1
46307	2
46314	1
46408	1
60025	1
60039	1
60056	2
60060	1
60064	1
60070	2
60085	1
60099	1
60101	1
60106	2
60131	2
60133	1
60153	3
60155	3
60160	3
60164	1
60165	1
60171	2
60176	3
60181	1
60185	2
60305	2
60344	1
60402	1
60404	1
60406	3
60407	1
60409	3
60411	10
60414	1
60415	2
60417	1
60418	2
60419	1
60423	1
60425	2
60426	6

ATTACHMENT 25C5

65

60428	1
60429	4
60432	1
60433	1
60435	2
60436	1
60438	1
60440	1
60441	1
60442	1
60443	4
60445	2
60446	2
60452	1
60453	2
60455	3
60458	1
60465	2
60466	3
60469	1
60477	3
60478	1
60501	1
60504	2
60506	1
60517	2
60555	2
60586	3
60605	3
60608	5
60609	4
60612	2
60614	1
60615	2
60616	4
60617	9
60618	1
60619	8
60620	6
60621	3
60622	1
60623	7
60624	4

ATTACHMENT 25C5

60625	1
60628	9
60629	13
60631	1
60632	9
60633	2
60634	4
60637	5
60638	2
60639	2
60641	1
60643	7
60644	3
60645	3
60646	3
60649	5
60652	5
60653	6
60659	1
60707	1
60803	2
60804	4
60805	1
60827	2
60901	2
60901	1
60950	1
61068	1

ATTACHMENT 25C5

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following number of patients on the hospitals or licensed ASTCs identified below.

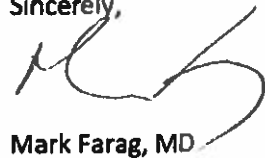
	<u>2016</u>	<u>2017</u>
Hyde Park Surgical Center, LLC	28 patients	36 patients
Office Procedures	2128 patients	2240 patients

I estimate that I will refer 50 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 patients.

The information contained in this letter is true and correct, to the best of my information and belief, and had not been used in the support of another project.

Sincerely,

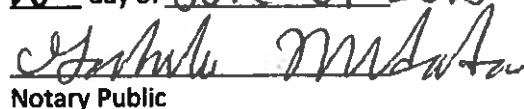


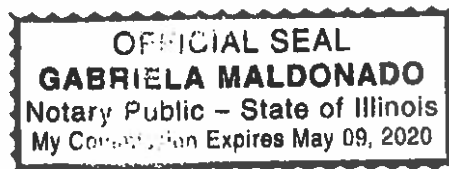
Mark Farag, MD
Anesthesiology and Pain Medicine

Notarized:

Subscribed and Sworn to before
me this

18th day of June of 2018


Notary Public



ATTACHMENT 25C5

CP

ZIP CODE	COUNT
60153	1
60176	1
60404	1
60415	1
60419	1
60429	1
60440	1
60458	1
60506	1
60608	2
60614	1
60616	1
60617	1
60618	1
60620	1
60623	1
60628	1
60629	6
60632	3
60634	1
60638	1
60647	1
60649	1
60652	1
60653	1
60706	1
60804	2

ATTACHMENT 25C5



ORTHOPAEDICS AND RHEUMATOLOGY
OF THE NORTH SHORE

Physician Name: Dr. Steven Sclamberg

Specialty: Orthopedic Surgery

TO: Illinois Health Facilities Planning Board
Springfield, Illinois

This letter is being provided in response to Review Criterion 1110.1540(c) in support of the proposed ambulatory surgical treatment center (ASTC) to be established in Des Plaines, Illinois.

During 2016 and 2017 I performed outpatient surgical procedures on approximately the following numbers of patients in the hospitals or licensed ASTCs identified below.

	<u>2016</u>	<u>2017</u>
Presence St. Francis Hospital	313 patients	344 patients

I estimate that I will refer 175 patients to the proposed ASTC during its second year of operation.

Attached is a patient origin analysis of my 2017 outpatients.

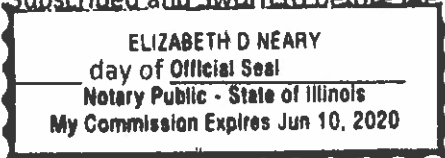
The information contained in this letter is true and correct, to the best of my information and belief, and has not been used in the support of another project.

Sincerely,

Steven Sclamberg, MD

Notarized:

Subscribed and Sworn to before me this



Notary Public

Elizabeth D. Neary
5/29/18

ORTHOPAEDICS

STEVEN G. SCLAMBERG, MD

EDWARD L. SCLAMBERG, MD

RHEUMATOLOGY

ERIN L. ARNOLD, MD FACR

WILLIAM J. ARNOLD, MD FACP, MACR

PHONE 847-869-7233

FAX 847-869-7233

ATTACHMENT 25C5
4709 W. GOLF ROAD, SUITE 1200
SKOKIE, ILLINOIS 60076

70

Zip Code	TotalForZipCode
10022	1
22191	1
28277	1
31719	1
33156	1
46307	1
46342	1
46410	1
53095	1
53158	1
53181	1
53534	1
54540	1
60002	2
60004	4
60005	5
60007	3
60008	3
60010	3
60012	1
60013	1
60015	45
60016	20
60018	5
60021	1
60022	27
60025	46
60026	14
60030	4
60031	5
60035	85
60040	3
60044	1
60045	4
60046	2
60047	4
60048	6
60051	1
60053	57
60056	10
60060	4
60061	5
60062	45
60067	4
60068	14
60069	5

ATTACHMENT 25C5

60070	2
60070	2
60073	1
60074	2
60074	2
60076	122
60077	75
60085	1
60089	12
60090	12
60091	44
60093	18
60097	1
60101	1
60102	2
60102	2
60103	1
60104	1
60106	3
60106	3
60106	3
60107	1
60108	1
60118	1
60119	1
60123	1
60136	1
60137	1
60139	1
60142	1
60143	2
60143	2
60156	1
60162	1
60173	1
60176	1
60189	1
60192	1
60193	3
60194	1
60201	67
60202	78
60203	11
60208	1
60302	2
60304	1
60401	1

ATTACHMENT 25C5

60402	2
60406	1
60409	1
60422	1
60430	2
60431	1
60465	2
60473	2
60510	1
60516	1
60527	1
60534	1
60540	1
60554	1
60560	1
60564	1
60601	2
60602	1
60603	1
60605	1
60606	1
60607	3
60608	2
60609	2
60610	9
60611	5
60612	1
60613	4
60614	16
60616	2
60617	1
60618	22
60619	5
60621	1
60622	9
60625	29
60626	53
60628	2
60629	1
60630	38
60631	21
60632	2
60634	22
60637	1
60638	1
60639	4
60640	24

ATTACHMENT 25C5

60641	19
60643	1
60644	1
60645	97
60646	31
60647	7
60649	1
60651	7
60653	1
60654	1
60655	1
60656	9
60657	11
60659	30
60660	29
60678	1
60706	6
60707	3
60712	40
60714	30
60804	2
60950	1
61108	1
62807	1
62959	1
65109	1
76112	1
80304	1
84734	1
85014	1
90059	1
98682	1
98687	1

SERVICE ACCESSIBILITY

The proposed ASTC is necessary to improve access to the services to be provided; those being pain management, orthopedic surgery, and particularly neurological surgery.

While there are eight ASTCs located within ten miles of the proposed suburban Cook County site, n of those ASTCs provide neurological surgery services, resulting in area residents having to travel significant distances to benefit from neurological surgery services provided through the lower-cost ASTC setting. The proposed project will located ASTC-based outpatient neurological surgery services in the GSA, providing accessibility that does not currently exist, per Section 1110.234.c.6.B).

UNNECESSARY DUPLICATION/MAL-DISTRIBUTION

The proposed project will not result in an unnecessary duplication or a mal-distribution of services.

The geographic service area ("GSA"), per IDPH rule, consists of those communities and ZIP Code areas located within ten miles of the proposed site. This area generally covers the communities from Deerfield on the north, to Lake Michigan on the east, to River Grove on the south and Rolling Meadows on the west. The population of the GSA, identified on a ZIP-Code specific basis is approximately 3,980,000 per GeoLytics.

Eight ASTCs and eight hospitals are located in the GSA, and identified in the table on the following page. Of note is the fact that none of the ASTCs provides neurosurgery services and only two provide pain management services.

ASTCs and Hospitals Located in GSA

Facility	Location	Pain Management*	Neurosurgery	Orthopedic Surgery
Apollo Health Center	Des Plaines			
Chicago Surgical Center	Des Plaines			X
Foot & Ankle Surgical Center	Des Plaines			X
Golf Surgical Center	Des Plaines	X		X
Illinois Hand & Upper Extremity Ctr.	Arlington Heights			X
Ill. Sports Med. & Orthopedic Ctr.	Morton Grove			X
Novamed Surgery Center of Chicago	Chicago			
Regenerative Surgery Center	Des Plaines	X		X
Advocate Lutheran General Hospital	Park Ridge	X	X	
Presence Holy Family Hospital	Des Plaines	X		
Presence St. Francis Hospital	Evanston	X	X	X
Evanston Hospital	Evanston	X	X	X
Skokie Hospital	Skokie	X	X	X
Community First Hospital	Chicago	X	X	X
Alexian Brothers Medical Center	Elk Grove Village	X	X	X
Northwest Community Hospital	Arlington Heights		X	X

* ASTCs having performed pain management procedures in 2017 and hospitals with a pain management procedure room

The proposed project will not result in a mal-distribution of services for two reasons:

First, the residents of the GSA are currently negatively impacted in a significant manner due to the existing mal-distribution of services, which will, as a result of the proposed project, be partially allayed. Specifically, per 2016 IDPH facility *Profiles*, the hospitals and ASTCs in the GSA provide a total of 186 operating rooms and procedure rooms, resulting in one OR/procedure room per 21,397 GSA residents. Based on IDPH hospital and ASTC *Data Summaries*, state-wide, there are 2,904 operating rooms and procedure rooms. Using the 2020 population projection provided on the HFSRB website, the state's population of 13,129,223 results in an OR/procedure room : population rate of 1 OR/procedure room per 4,521 residents. With the GSA rate being approximately 4.7 times that of the state as a whole, a clear mal-distribution to the detriment of GSA residents exists.

Second, and as noted earlier in this ATTACHMENT, no ASTCs in the GSA provide neurosurgery/neurological surgery services, resulting in a mal-distribution and a lack of access to lower cost outpatient neurosurgery services provided in an ASTC setting.

As is the case with virtually all ASTC projects, the applicant is unable to document with certainty that within 24 months after project completion, the proposed project will neither lower the utilization rate of other area providers below the target utilization standard or lower the utilization rate of facilities failing to meet the utilization standard.

STAFFING

In evaluating the potential establishment of an ASTC, the applicant took into consideration relevant clinical and professional staffing requirements; and the applicant is confident that all staffing requirements required for IDPH licensure, as well as the staffing-related requirements of the major ASTC accrediting bodies can and will be met.

With the exception of a Medical Director, the employee recruitment process will commence approximately six months pre-opening. ASTC positions are highly-sought after, and no difficulties are anticipated in the recruitment of nurses, OR technicians, and other employees; which will be recruited through typical means, such as advertisements in local newspapers and professional journals. Dr. Darrel Saldanha, who is Board Certified in anesthesiology and pain management will serve as the ASTC's initial Medical Director.

CHARGE COMMITMENT

With the signatures placed on the Certification page of this *Application for Permit*, the applicant certifies that the charges identified in this ATTACHMENT to the *Application for Permit* will not be increased, at minimum, for two years following the opening of the proposed ASTC, unless a *Permit* is first obtained pursuant to 77 Ill. Adm. Code 1130.310(a).

A master charge list for the procedures envisioned to be performed at the proposed ASTC during its first two years of operation is attached.

**North Suburban Pain & Spine Center
Charge Master**

CPT Code	Description	Fee
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	\$1,302
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level	\$1,302
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic	\$873
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal)	\$873
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic	\$1,080
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic	\$1,080
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral	\$1,080
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral	\$1,080
64635	Destruction by neurolytic agent paravertebral facet joint nerve(s) (fluoroscopy or CT; Lumbar or sacral, single facet joint	\$2,421
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc	\$9,036
22551	Anterior or Anterolateral Approach Technique Arthrodesis Procedures on the Spine (Vertebral Column)	\$22,618

ATTACHMENT 25C-9

**North Suburban Pain & Spine Center
Charge Master**

CPT Code	Description	Fee
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	\$5,859
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	\$5,859
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed	\$5,859
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	\$9,314
23515	Fracture and/or Dislocation Procedures on the Shoulder	\$11,711
23550	Open treatment of acromioclavicular dislocation, acute or chronic	\$8,390
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament	\$5,860
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	\$60,000
C1767	Generator, neurostimulator (implantable), non-rechargeable	Incl w/ 63685
C1778	Lead, neurostimulator (implantable)	Incl w/ 63685
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	Incl w/ 63685
C1897	Lead, neurostimulator test kit (implantable)	Incl w/ 63685
C1883	Adaptor/extension, pacing lead or neurostimulator lead (implantable)	Incl w/ 63685
C1787	Patient programmer, neurostimulator	Incl w/ 63685

ATTACHMENT 25C-9

ASSURANCES

With the signatures placed on the Certification page of this *Application for Permit*, the applicant attests that a peer review program will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Further, with the signatures placed on the Certification page of this *Application for Permit*, the applicant anticipates that in the second year of operation, the annual utilization of the operating rooms will meet or exceed the utilization standard specified in 77 Ill. Adm. Code 1100. This anticipation is based on the applicant's knowledge of the practices of the physicians anticipated to refer patients to the proposed ASTC.

North Suburban Pain & Spine Center **Financial Ratios**

Based on the Year 2 Balance Sheet and P&L

Current Ratio (a) / (b)		<u><u>3.31</u></u>	Target	> 1.5
(a)	Current Assets	1,705,358		
(b)	Current Liabilities	515,909		
Net Margin Percentage (d) / (c) * 100		<u><u>21.22</u></u>	Target	> 3.5
(c)	Net Operating Revenues	3,863,976		
(d)	Net Income	820,109		
Long Term Debt to Capitalization Ratio (f) / ((f) +(g)) * 100		<u><u>51.36</u></u>	Target	< 80
(f)	Long Term Debt	1,639,696		
(g)	Net Assets	1,552,695		
Projected Debt Service Coverage ((e)+(h)+(i))/((i)+(j))		<u><u>3.60</u></u>	Target	> 1.75
(e)	Net Income	820,109		
(h)	Depreciation	336,430		
(i)	Interest Expense	110,687		
(j)	Principal Paydown	241,617		
Days Cash on Hand (k)/((l)-(h))/365)		<u><u>164.79</u></u>	Target	> 45
(k)	Cash	1,222,361		
(l)	Operating Expenses	3,043,867		
(h)	Depreciation	336,430		
Cushion Ratio (k)/((i)+(l))		<u><u>3.47</u></u>	Target	> 3
(k)	Cash	1,222,361		
(i)	Interest Expense	110,687		
(j)	Principal Paydown	241,617		

Financial Ratios

ATTACHMENT 36

**North Suburban Pain & Spine Center
Profit & Loss**

	<u>Year 1</u>	<u>Year 2</u>
Revenue, Net of Contractual Allowances	3,049,982	3,863,976
Clinical Expenses		
Medical Supplies	865,670	1,123,826
Clinical Staff	444,288	457,617
	<u>1,309,958</u>	<u>1,581,443</u>
Gross Margin	1,740,024	2,282,533
Administrative Expenses		
Rent	118,975	121,949
Bad Debt	91,499	115,919
Charity Care	30,500	38,640
Admin Staff	309,696	318,987
Transcription	32,508	40,032
Medical Director	50,000	50,000
Linens & Laundry	62,307	76,728
Office Supplies	18,630	18,630
Equipment Repairs & Maintenance	10,000	10,000
Equipment Service Contracts	25,000	25,000
Housekeeping	8,500	8,500
Waste (Hazardous) Removal	22,349	27,522
Utilities	15,000	15,000
Malpractice & Business Insurance	22,250	26,000
Telephone	6,200	6,200
Dues, Subs & Licenses	4,200	4,200
Legal / Professional Fees	12,000	12,000
AAAHF Fees	12,000	-
Depreciation Expense	334,430	336,430
Interest Expense	118,368	110,687
Other	100,000	100,000
	<u>1,404,412</u>	<u>1,462,424</u>
Administrative Expenses	<u>1,404,412</u>	<u>1,462,424</u>
Net Income (Loss)	<u>335,612</u>	<u>820,109</u>

Profit & Loss

ATTACHMENT 36

85

**North Suburban Pain & Spine Center
Balance Sheets**

	<u>Year 1</u>	<u>Year 2</u>
Current Assets		
Cash	451,439	1,222,361
Accounts Receivable	482,997	482,997
Total Current Assets	934,436	1,705,358
Fixed Assets, Net	2,119,869	1,793,439
Other Assets		
Certificate of Need	199,650	199,650
Deposits	9,853	9,853
Total Other Assets	209,503	209,503
	<u>3,263,808</u>	<u>3,708,300</u>
Current Liabilities		
Line of Credit	385,000	325,000
Current Portion Long Term Debt	181,617	190,909
Total Current Liabilities	566,617	515,909
Long Term Debt	1,830,605	1,639,696
Total Liabilities	2,397,222	2,155,605
Members' Capital	866,586	1,552,695
	<u>3,263,808</u>	<u>3,708,300</u>

Balance Sheets

ATTACHMENT 36

85

Illinois Health Facilities
and Services Review Board
Springfield, Illinois

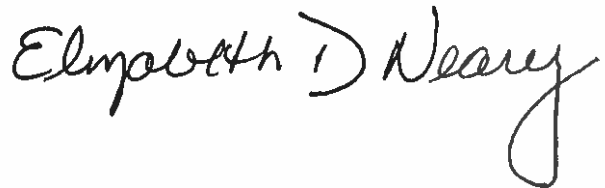
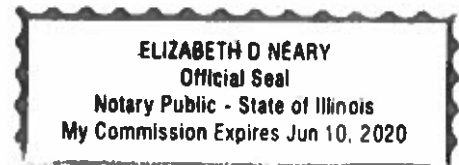
To Whom It May Concern:

It is my belief that the terms and conditions of the debt financing associated with the establishment of North Suburban Pain and Spine Center are reasonable, and at the present time, represent the lowest net cost available to the applicant. Further, it is my belief that the leasing of space for the ASTC is less costly than the construction of a freestanding building. Last, it is not anticipated that equipment will be leased in conjunction with the proposed project.



Darrel Saldanha, MD
Chief Executive Officer

Notarized:



ATTACHMENT 37B



Republic Bank

6/7/2018

North Suburban Pain and Spine Center, LLC
Darrel J. Saldanha, M.D.
John Saldanha
9680 Golf Road
Des Plaines, IL 60016

RE: Proposed Terms Loan \$900,000.00 Equipment

Dear Mr. Saldanha:

REPUBLIC BANK ("BANK") MAKES THE FOLLOWING PROPOSAL CONCERNING THE ABOVE CAPTIONED PROPERTY. PLEASE KEEP IN MIND THAT THIS IS GENERAL OUTLINE OF TERMS AND CONDITIONS FOR DISCUSSION PURPOSES ONLY AND SHOULD NOT BE CONSTRUED AS A COMMITMENT TO FINANCE. ALL LOANS REQUIRE THE APPROVAL OF REPUBLIC BANK'S LOAN COMMITTEE.

BORROWER:

North Suburban Pain and Spine Center, LLC

GUARANTOR(S):

Full unconditional joint and several personal guarantees from individuals acceptable to Republic Bank. Additional corporate guarantors acceptable to Republic Bank will be required as well.

PURPOSE:

To provide financing for medical equipment to be utilized by North Suburban Pain and Spine Center, LLC

LOAN AMOUNT:

The loan amount shall be \$900,000.00

COLLATERAL:

UCC-1/PMSI on all equipment to be financed for North Suburban Pain and Spine Center, LLC

INTEREST RATE:

Prime +1.00%, floating for the first 12 months

Converting to the current WSJ Prime +1.00% Fixed for 60 month term loan

TERM:

12 month interest only loan converting to a fully amortizing 60 month term

Total term will be 72 months

LOAN FEE:

The loan fee shall total ½% of the loan amount

This does not include additional administrative costs.

REPAYMENT:

Interest only for the first 12 months converting to a Principal and Interest payments over a 72 month loan



Republic Bank

PREPAYMENT PENALTY:

N/A

EXPENSES:

Borrower shall reimburse Bank in advance for any costs incurred by Bank in connection with the application and administration of this loan. These expenses include but are not limited to appraisal fees, loan origination fees, and legal/documentation fees.

ADDITIONAL LOAN REQUIREMENTS:

1. Automatic debit of required monthly payments from RBC DDA for the life of the loan.
2. Borrower to maintain primary deposit operating accounts with RBC for the life of the loan.
3. Borrower shall provide proper insurance acceptable to Bank
4. Each draw request will be reviewed by RBC Credit Administration and signed borrowing bases are required with each draw.
5. Borrower shall provide Bank periodic financial information

This letter is not a commitment by Bank to provide any financing, but is rather a preliminary and tentative proposal of terms. All loans are subject to completion of our review and analysis of your financial condition, business prospects, evaluation of assets provided as collateral, negotiation of terms, conditions and documentation which is acceptable to Bank and Bank Counsel, approval by appropriate officials of the Bank, and final Bank underwriting.

Please let me know if you have any questions regarding the parameters outlined in this proposal letter. If the above terms and conditions are acceptable, please execute this proposal letter and send to my attention. Thank you for allowing Republic Bank this opportunity to entertain your business.


Sincerely,

REPUBLIC BANK

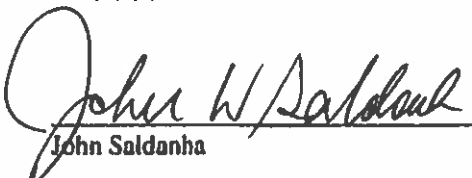

Peter J. Sperling
SVP Commercial Lending/BDO Manager

Date: 6/7/18

Accepted By:


Darrel Saldanha

Date: 6/9/18


John W. Saldanha

Date: 6-9-18



6/7/2018

North Suburban Pain and Spine Center, LLC
Darrel J. Saldanha, M.D.
John Saldanha
9680 Golf Road
Des Plaines, IL 60016

RE: PROPOSED TERMS \$1,280,000.00
Golf Road Project
Des Plaines, Illinois

Dear Darrel Saldanha:

REPUBLIC BANK ("BANK") MAKES THE FOLLOWING PROPOSAL CONCERNING THE ABOVE CAPTIONED PROPERTY. PLEASE KEEP IN MIND THAT THIS IS GENERAL OUTLINE OF TERMS AND CONDITIONS FOR DISCUSSION PURPOSES ONLY AND SHOULD NOT BE CONSTRUED AS A COMMITMENT TO FINANCE. ALL LOANS REQUIRE THE APPROVAL OF REPUBLIC BANK'S LOAN COMMITTEE.

BORROWER:

North Suburban Pain and Spine Center, LLC

GUARANTOR(S):

General Property Management LLC

Full unconditional joint and several personal guarantees from individuals acceptable to Republic Bank.
Additional corporate guarantors acceptable to Republic Bank will be required as well.

PURPOSE:

To provide tenant improvements for a new location for North Suburban Pain and Spine Center, LLC
- 9680 Golf Road, Des Plaines, IL 60016

LOAN AMOUNT:

The loan amount shall be \$1,280,000.00 on a tenant improvement budget of \$1,600,000.00

COLLATERAL:

UCC-1 on all business assets located at 9680 Golf Road, Des Plaines, IL 60016

2nd mortgage and assignment of rents located at 9680 Golf Road, Des Plaines, IL 60016

This loan will be cross collateralized with the development loan to General Property Management LLC

INTEREST RATE:

The loans shall bear interest at Prime + 1%, with a floor of 5.0%. for the first 12 mos.

The rate will convert to a fixed rate based on the current WSJ Prime rate of interest +1% for the remaining 60 months

90



Republic Bank

TERM:

12 month interest only loan converting to a fully amortizing 60 month term
Total term will be 72 months

LOAN FEE:

The loan fee shall total 1/2% of the loan amount
This does not include additional administrative costs.

REPAYMENT:

Interest only for the first 12 months converting to a Principal and Interest payments over a 60 month loan

PREPAYMENT PENALTY:

N/A

EXPENSES:

Borrower shall reimburse Bank in advance for any costs incurred by Bank in connection with the application and administration of this loan. These expenses include but are not limited to appraisal fees, loan origination fees, and legal/documentation fees.

ADDITIONAL LOAN REQUIREMENTS:

1. Borrower shall be required to establish and maintain the operating project accounts, as a deposit relationship with Bank.
2. Borrower shall provide proper insurance acceptable to Bank.
3. All loan disbursements shall be funded through a Bank approved title company escrow account.
4. Borrower shall provide proper permits, government approvals, licenses, and any other operation documentation to Bank before opening of the Loan.
5. Borrower shall provide Bank a copy of detailed plans and costs for the subject tenant improvement project.
6. All Loan disbursements shall be funded through a Bank approved title company escrow account.
7. All significant loan draws shall be subject to Bank and Bank's independent inspection firm's review prior to funding requirement.
8. Payment of all architect fees, legal fees, government fees, engineering fees, project management fees, and all other soft costs shall be detailed on a sworn owner's statement submitted to title company before each Loan draw funding.
9. Borrower shall provide Bank periodic financial information and sales/leasing updates on this project.



Republic Bank

This letter is not a commitment by Bank to provide any financing, but is rather a preliminary and tentative proposal of terms. All loans are subject to completion of our review and analysis of your financial condition, business prospects, evaluation of assets provided as collateral, negotiation of terms, conditions and documentation which is acceptable to Bank and Bank Counsel, approval by appropriate officials of the Bank, and final Bank underwriting.

Please let me know if you have any questions regarding the parameters outlined in this proposal letter. If the above terms and conditions are acceptable, please execute this proposal letter and send to my attention. Thank you for allowing Republic Bank this opportunity to entertain your business.

Sincerely,

REPUBLIC BANK

Date:

6/7/18

Peter J. Sperling
SVP Commercial Lending/BDO Manager

Accepted By:

6/9/18

Darrel Saldanha

Date

6-9-18

John Saldanha

Date

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE

	Cost/Sq. Ft.		DGSF		DGSF		New Const. \$ (A x C)	Modernization \$ (B x E)	Costs (G + H)
	New	Mod.	New	Circ.	Mod.	Circ.			
Reviewable									
ASTC-Surgery		\$ 240.00		2,620				\$ 628,800	\$ 628,800
ASTC-Recovery		\$ 200.00		2,620				\$ 524,000	\$ 524,000
Contingency		\$ 10.00						\$ 52,400	\$ 52,400
		\$ 230.00		5,240				\$ 1,205,200	\$ 1,205,200
Non-Reviewable									
Public Areas		\$ 170.00		600				\$ 102,000	\$ 102,000
Admin/Business Areas		\$ 170.00		520				\$ 88,400	\$ 88,400
Staff Areas		\$ 170.00		620				\$ 105,400	\$ 105,400
Contingency		\$ 10.00						\$ 17,400	\$ 17,400
		\$ 180.00		1,740				\$ 313,200	\$ 313,200
Total		\$ 217.54		6,980				\$ 1,518,400	\$ 1,518,400

PROJECTED OPERATING COSTS
and
TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS

NORTH SUBURBAN PAIN AND SPINE CENTER
YEAR 2 OPERATING COST per SURGICAL CASE

Projected Cases: 1,677

Salaries	\$352,460
Benefits	\$105,280
Medical Supplies	<u>\$994,140</u>
	\$1,451,880
per Surgical Case:	\$ 865.76

YEAR 2 CAPITAL COST per SURGICAL CASE

Projected Cases: 1,677

Interest Expense	\$ 428,736
Depreciation & Amort.	<u>\$ 336,432</u>
	\$ 765,168
per Surgical Case:	\$ 456.27

SAFETY NET IMPACT STATEMENT

Due to the nature of an ASTC, such facilities are not providers of safety net services, with all procedures scheduled on an elective basis. The applicant, however, intends that the proposed ASTC becomes a valued member of the community, and to the extent reasonable, anticipated participation in community-based events, such as health fairs is anticipated.

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	24
2	Site Ownership	25
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	28
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	29
5	Flood Plain Requirements	30
6	Historic Preservation Act Requirements	32
7	Project and Sources of Funds Itemization	33
8	Financial Commitment Document if required	
9	Cost Space Requirements	35
10	Discontinuation	
11	Background of the Applicant	36
12	Purpose of the Project	37
13	Alternatives to the Project	38
14	Size of the Project	40
15	Project Service Utilization	41
16	Unfinished or Shell Space	
17	Assurances for Unfinished/Shell Space	
18	Master Design Project	
	Service Specific:	
19	Medical Surgical Pediatrics, Obstetrics, ICU	
20	Comprehensive Physical Rehabilitation	
21	Acute Mental Illness	
22	Open Heart Surgery	
23	Cardiac Catheterization	
24	In-Center Hemodialysis	
25	Non-Hospital Based Ambulatory Surgery	42
26	Selected Organ Transplantation	
27	Kidney Transplantation	
28	Subacute Care Hospital Model	
29	Community-Based Residential Rehabilitation Center	
30	Long Term Acute Care Hospital	
31	Clinical Service Areas Other than Categories of Service	
32	Freestanding Emergency Center Medical Services	
33	Birth Center	
	Financial and Economic Feasibility:	
34	Availability of Funds	
35	Financial Waiver	
36	Financial Viability	84
37	Economic Feasibility	87
38	Safety Net Impact Statement	95
39	Charity Care Information	23

Axel & Associates, Inc.

MANAGEMENT CONSULTANTS

by FedEx

June 25, 2018

Ms. Courtney Avery
Administrator
Illinois Health Facilities and
Services Review Board
525 West Jefferson
Springfield, IL 62761

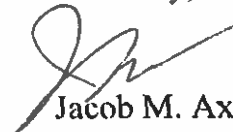
Dear Ms. Avery:

Enclosed please find two copies of a Certificate of Need ("CON") application addressing the establishment of an ASTC in Des Plaines, Illinois, filed on behalf of North Suburban Pain and Spine Center, LLC.

The application is accompanied with a check, in the amount of \$2,500.00, as a filing fee.

Should any additional information be required, please do not hesitate to contact me.

Sincerely,



Jacob M. Axel
President

enclosures